

5053

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Bel Alton.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BARGDILL				4. DATE OF DEATH Month Day Year MAY 13 1956			
5. SEX MALE	6. COLOR OR RACE US-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1956		9. AGE (In years lost birthday) yrs. —	IF UNDER 1 YEAR Months Days Hours Min. — 3 — —	IF UNDER 24 HRS. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) La Plata, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilburn M. BARGDILL				14. MOTHER'S MAIDEN NAME Rose Elizabeth McCarthy.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Address W. M. BARGDILL, Bel Alton, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory collapse 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity. (infant about 24 wks gestation) DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10 May , 19 56 , to 13 May , 19 56 , that I last saw the deceased alive on 13 May , 19 56 , and that death occurred at 7:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED La Plata Maryland 13 May 56							
ACTUAL SIGNATURE A. Wooddy M.D.				22. REGISTRAR'S SIGNATURE Julia H. Pusey			
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/13/56		22c. NAME OF CEMETERY OR CREMATORY St Ignatius		22d. LOCATION (City, town, or county) (State) BEL ALTON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. M. BARGDILL, Bel Alton, MD				24a. REC'D BY REGISTRAR DATE 5/14/56		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066394XVI

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING 18

BUREAU V. S.

MAY 15 1956

RECEIVED

5054

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician Memorial Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>LORENZO</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas Carter</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Rose Floyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-18-843</u>	
17. INFORMANT Address <u>Alberta Carter La Plata Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Extreme hypertension</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-4</u> , 19 <u>56</u> , to <u>5-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-4</u> , 19 <u>56</u> , and that death occurred at <u>4:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Johnson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-8-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Waldorf Md</u>		24. REC'D BY REGISTRAR <u>MAY 10 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. L. Hall Poy</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

MAY 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05051
5055 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **100**

1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Labeta c. LENGTH OF STAY IN TB 7 wks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE md b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Labeta d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenny William Casteel 5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 3-30-56 9. AGE (In years last birthday) 0 yrs. 10. IF UNDER 1 YEAR Months 7 Days 18 11. IF UNDER 24 HRS. Hours 1 Min. 18		4. DATE OF DEATH Month 5 Day 18 Year 1966 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 10b. KIND OF BUSINESS OR INDUSTRY md. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Kenny Casteel 14. MOTHER'S MAIDEN NAME Eva Jean Kaiser 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT 11 4 Address Labeta md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE F. J. EDELEN M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) F. J. EDELEN M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-18-66 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/19/66 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) St. Paul Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Address 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Kenny Casteel (Funder) Labeta, md DATE 5/18/66 James H. Carey			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE BOARD OF HEALTH
STATE OF NEW YORK
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

BUREAU V. 5

MAY 21 1956

RECEIVED

5056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05052

Reg. Dist. No.

103

1. PLACE OF DEATH a. COUNTY Waldorf, Charles Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Joan Yvett Duckett		4. DATE OF DEATH Month May Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-1956
9. AGE (In years last birthday) 3 MO 0 yrs.		IF UNDER 1 YEAR Months 3 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Robert Duckett		14. MOTHER'S MAIDEN NAME Hazel Bernardine Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Hazel Duckett, Waldorf, Md. (Mother)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation (Accidental) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 Hours
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Baby found dead in crib, on stomach with head in pillow		
20c. TIME OF INJURY Month, Day, Year 6 Hour o. m. 5-3- 19 56 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Waldorf Charles Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William J. Kurz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William J. Kurz, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 4 1956	22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Stunt Funeral Home		24. REC'D BY REGISTRAR Waldorf	24b. REGISTRAR'S SIGNATURE M. L. Monro

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4000340405

RECEIVED

MAY 7 1956

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05053

CERTIFICATE OF DEATH

Reg. Dist. No.

100

5057

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Chas</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seatons</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT Victoria</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physician's Office</u>		d. STREET ADDRESS <u>MT Victoria</u>	
3. NAME OF DECEASED (Type or print) <u>VIRGIE</u> First <u>DXSON</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 6 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Dyson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>6 Ethel Key</u>	
17. INFORMANT <u>Mt Victoria MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>240X</u> (b) <u>Renal arteriosclerosis</u> (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 yrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral infarct 3 years ago, diabetes, gangrene rt. foot</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 1955</u> to <u>23 May 1956</u> , that I last saw the deceased alive on <u>22 May 1956</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. M. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>LA PLATA, MD</u> DATE SIGNED <u>5-23-56</u>	
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shilo</u>		22d. LOCATION (City, town, or county) (State) <u>Waynes, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Funeral Home Waldorf Md</u>		24a. REC'D BY REGISTRAR <u>MAY 29 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. F. Wells Bayne</u>	

CERTIFICATE OF DEATH

BUREAU V. 3

MAY 29 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>		STATE <i>Del.</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Rison</i>	LENGTH OF STAY (In this place) <i>70 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rison</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>James</i>		<i>July 30 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 4, 1881</i>
9. AGE last birthday <i>75</i> yrs.		10. IF UNDER 1 YEAR (Months) Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Steel Products Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Not Known</i>		14. MOTHER'S MAIDEN NAME <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Mrs J.S. Ennis, Rison, Del.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
4424 IMMEDIATE CAUSE (A) <i>Hypertension & Heart Disease</i>			<i>21 yrs.</i>
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hemiplegia</i>			<i>21 yrs.</i>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/> Not el work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from, 19 <i>35</i> , to <i>July 28</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>July 28</i> , 19 <i>56</i> , and that death occurred at <i>12 Mid-night</i> from the causes and on the date stated above.			
SIGNATURE <i>Frank H. Quisenberry M.D.</i>		ADDRESS (Street, city, town, state) <i>Indian Head, Del.</i>	
		DATE SIGNED <i>5-31-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>	DATE THEREOF <i>6-3-56</i>	NAME OF CEMETERY OR CREMATORY <i>Alexander B.E. Church.</i>	LOCATION (City, town, or county) (State) <i>Chicodunks Del.</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>Mary Southland</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson and Jenkins</i>	
DATE <i>June 2, 1956</i>		ADDRESS <i>1702-12th St.</i>	

574016-902/15N

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

THE

W. A. P.

1871

1871

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5059 CERTIFICATE OF DEATH

05055

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Charles</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newburg</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newburg</u>	STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (First) (Middle) (Last) <u>J. EARL HILL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 19 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Jan 16 1890</u>
9. AGE last birthday <u>66</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>St Marys Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	13. FATHER'S NAME <u>Perry Hill</u>		
14. MOTHER'S MAIDEN NAME <u>Catherine P.</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS <u>Beatrice Mattingly Laplata</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
2. ANTECEDENT CAUSE(S) (B) <u>Hypertension</u>		<u>15 yrs.</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>		<u>30 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Previous Cerebral thrombosis</u>		<u>10 yrs.</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 1954</u> , to <u>May 19 1956</u> , that I last saw the deceased alive on <u>Apr 15 1956</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Frederick M. Johnson</u>		DATE SIGNED <u>2A PLATA, Md. 19 May 56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>5/22/56</u>	NAME OF CEMETERY OR CREMATORY <u>St Ignatious</u>	LOCATION (City, town, or county) (State) <u>Belknap Md</u>
24. REC'D BY REGISTRAR <u>5/22/56</u>	REGISTRAR'S SIGNATURE <u>Julia H. Pacey</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard J. Laplata</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05056

5060

CERTIFICATE OF DEATH

Reg. Dist. No. 106

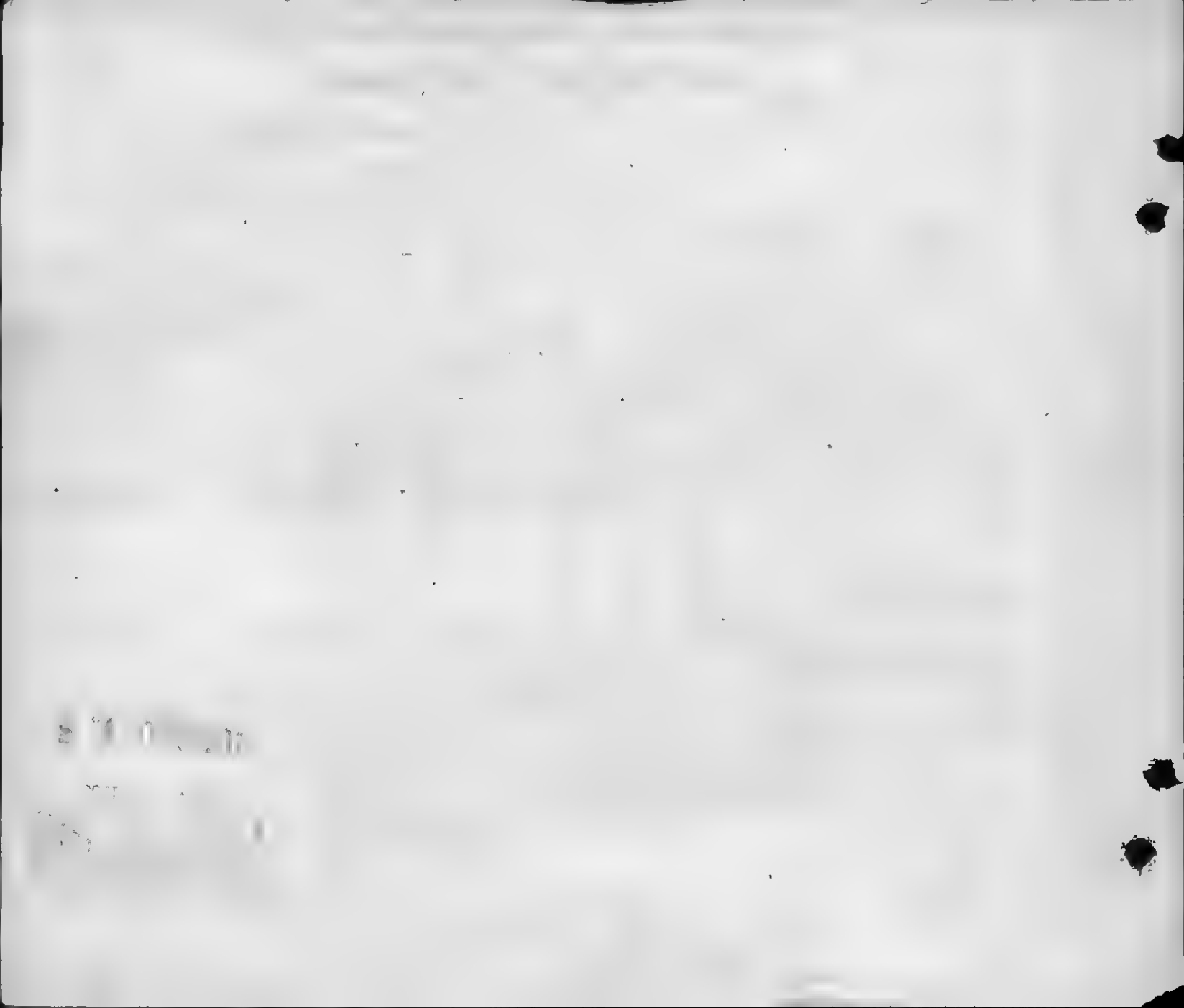
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Indian Head Md</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>2-Cypress Potomac Heights Indian Head Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>2-Cypress -Potomac Heights</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>PAUL ALFRED LINKOUS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5-28-56</u> 19			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>OCT. 11 1909</u>	9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>powder factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US GOV.</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Homer G. Linkous</u>				14. MOTHER'S MAIDEN NAME <u>Cora B. Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213 03 0895</u>		17. INFORMANT & ADDRESS <u>Cora B. Linkous Indian Head, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Coronary Heart Disease</u>						<u>Indefinite</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arterio-Sclerosis General</u>						<u>Indefinite</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-10-56, 19, to 5-28-56, 19, that I last saw the deceased alive on 5-28-56, 19, and that death occurred at 12:45 PM, from the causes and on the date stated above.							
SIGNATURE <u>James E. Andrews MD.</u>		DATE THEREOF <u>June 1 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) (State) <u>Blacksburg Va.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>June 1 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Oley Price</u>		DATE SIGNED <u>5-29-56</u>	
24. REC'D BY REGISTRAR <u>June 1 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for burial transit permit.

VS AISC 1-55 10M



5061

CERTIFICATE OF DEATH

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL FLOYD MC GUIGAN				4. DATE OF DEATH Month Day Year May 10 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 1908		9. AGE (In years last birthday) yrs 47		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrician		11. BIRTHPLACE (State or foreign country) Charles Co. Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Joseph Mc Guigan				14. MOTHER'S MAIDEN NAME Susan Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-18-1948		17. INFORMANT Geneva Mc Guigan		Address Waldorf, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Apoplexy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, pancreas DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1932 to May 10, 1956 , that I last saw the deceased alive on May 10, 1956 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Waldorf, Md. DATE SIGNED 5/14/56							
ACTUAL SIGNATURE George S. Weber				PHYSICIAN'S NAME (Type) George S. Weber			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11 1956		22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE 5/14/56	
				24b. REGISTRAR'S SIGNATURE M. L. Morris			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

BUREAU V. S.

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MAY 16 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 185058100
5362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 176

1. PLACE OF DEATH a. COUNTY <u>Lanhamville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanhamville md.</u>	
c. LENGTH OF STAY IN lb <u>4 years</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			

a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) <u>Miriam J. MOORE</u>		4. DATE OF DEATH <u>Month 3 Day 26 Year 19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1901</u> 54 yrs.
		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>10</u> Days <u>7</u>
			IF UNDER 24 HRS. Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Lanhamville</u>	11. BIRTHPLACE (State or foreign country) <u>Texas</u>	12. CITIZEN OF WHAT COUNTRY? <u>ad & a</u>
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13. FATHER'S NAME <u>Edgar A. Ingram</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Drooper</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Lewis Moore Jr.</u> Address <u>Same Item #2</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occ</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-26-56</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Lanhamville</u> (County) <u>Charles</u> (State) <u>md.</u>

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <u>E. J. EDELEN</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>5-26-56</u>
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/29/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) <u>Rockville</u> (State) <u>Maryland</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>	24a. REC'D BY REGISTRAR <u>6/1/56</u>	24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>
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25. A15ME(5) SM 9/55	26. REGISTRAR'S SIGNATURE <u>Julia T. Ward</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

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5063

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived? If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Memorial Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>William B. Rhodes</u> First Middle Last		4. DATE OF DEATH <u>May 18 1956</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>W. Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Marian Perkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>22-20-6422</u>	
17. INFORMANT <u>Dorothy Wood Register</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enter - Colitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1955</u> to <u>5/17 56</u> , that I last saw the deceased alive on <u>May 17 1956</u> , and that death occurred at <u>1304</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank A. Susan MD</u>		ADDRESS (Street, city or town, state) <u>Indian Head, Md</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Susan MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>	22d. LOCATION (City, town, or county) (State) <u>Indian Head Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Washington</u>	
24a. REC'D BY REGISTRAR <u>DATE 1 22 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Julia Posey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNNELL V. S.

MAY

1880

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05060 100

Reg. Dist. No.

280

5064

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Charlie Middle Searight Last Searight		4. DATE OF DEATH Month May Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1937
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months 9 Days 28	IF UNDER 24 HRS. Hours 28 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jumper		10b. KIND OF BUSINESS OR INDUSTRY Delivery Truck	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zollie Searight		14. MOTHER'S MAIDEN NAME Lurine Armstrong	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Lurine Searight, Leonardtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Cranial Hemmorrhage 823X DUE TO (b) Fractured Skull (Base) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Fractured Jaw and left Femur Neck PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile left roadway. Passenger thrown 25 Ft. away	
20c. TIME OF INJURY Month, Day, Year 12:50 a. m. 5 2:56 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 5	20f. (City or town) (County) (State) Hughesville Charles Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William J. Kurz		DATE SIGNED 5-2-'56	
EXAMINER'S NAME (Type) William J. Kurz, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Sandy Ridge	22d. LOCATION (City, town, or county) (State) Sandy Ridge, Alabama
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Mattingly, Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 5/3/56	
		24b. REGISTRAR'S SIGNATURE Glenn A. Hamer Mrs. L. Wells Passey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Medical Examiner		Signature of Coroner	
Date of Examination		Date of Death	

BUREAU V. 2

MAY 7 - 1966

RECEIVED

5085

CERTIFICATE OF DEATH

Reg. Dist. No.

101

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Welcome</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Gert</u> Middle <u>Rude</u> Last <u>WENK</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1887</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph Yamm</u>				14. MOTHER'S MAIDEN NAME <u>Ann E Welsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Etta Scott</u>		Address <u>Welcome MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis. Cardio-vascular disease 7 yrs</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>49</u> , to <u>May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 May</u> , 19 <u>56</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur O. Woody</u> M.D.				EST ADDRESS (Street, city or town, state) <u>La Plata</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>				DATE SIGNED <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT Rest</u>		22d. LOCATION (City, town, or county) (State) <u>LA PLATA</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hornett Funeral Home</u>				ADDRESS <u>Waldorf</u>		24a. REC'D BY REGISTRAR <u>MAY 8 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Mary A. Luthland</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

MAY 8 1956

RECEIVED